

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **238**

Primary Registration District No. **57234355**

Registrar's No. **46**

63-040732
STATE FILE NUMBER

FILED OCT 21 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY NEW MADRID		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY NEW MADRID	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN NEW MADRID		c. CITY OR TOWN NEW MADRID	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION NO		d. STREET ADDRESS (If outside, give location) 205 TENN.	
3. NAME OF DECEASED (Type or print) First LE ROY Middle WRIGHT Last WRIGHT		4. DATE OF DEATH Month OCT. Day 16 Year 63	
5. SEX M	6. COLOR OR RACE C	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/16/63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHIEF		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (City and state or country) NEW MADRID		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME CLEVELAND WRIGHT JR		13b. MOTHER'S MAIDEN NAME ROBERTHA REDMON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ---	
17. INFORMANT CLEVELAND WRIGHT JR		Address NEW MADRID MO	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NO MEDICAL ATTENDANT - PRESUMED TO BE NATURAL CAUSES. DUE TO (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour --- a.m. --- p.m. ---	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 4:00 P.M. to --- and last saw her/him alive on --- Death occurred at --- on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE L. B. Hedgepeth (Degree or title) Coroner		22b. ADDRESS New Madrid Mo	
22c. DATE SIGNED 10/16/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 10-11-63	23c. NAME OF CEMETERY OR CREMATORY SANDHILL	23d. LOCATION (City, town, or county) (State) NEW MADRID MO
24. FUNERAL DIRECTOR FRIENDS		25. DATE RECD. BY LOCAL REG. 10/16/63	
ADDRESS NEW MADRID		26. REGISTRAR'S SIGNATURE Jay Hedgepeth	

USE BLACK INK

OR

TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.